Module Seven

DOCUMENTATION BASICS

A learning module developed by the Bureau of Facility Standards to train residential care or assisted living facility staff.

Why you should take this training.

Providing assistance to residents in an assisted living facility is a very big responsibility. Learning about documentation will help you communicate the quality of service you provide to your residents.

What you will learn in this module:

- ✓ **Why it is important to document as a care provider.**
- ✓ **Things you need to know when you write in a resident's record.**
- ✓ **Documentation Do's and Don'ts.**
- ✓ **The documentation rules a residential care or assisted living facility needs to follow.**
- ✓ **What documentation is needed for changes in residents' health status and behaviors; incidents or accidents; and assistance with medication.**

What you need to do to take this training.

Ask your Administrator how she or he wants you to do the training. You can do the training on the computer or you can print the learning module and work with the printed pages. Generally, you can just work through the modules in the order they are listed.

Who to ask if you have questions about this training.

If you have questions about the way things are done in your facility, ask your Administrator. If you or your Administrator have questions or comments about the content of the training, ask your Administrator to

contact the Residential Care or Assisted Living Program Supervisor at the Bureau of Facility Standards.

Words to know:

Chronological - how things progress in time
Concise - to the point
Descriptive - paint a picture with words
Documentation - written communication regarding resident cares that is maintained in the facility
Legible - write so everyone can read what you wrote
Objective documentation - things that are observed using the senses, i.e. hear, feel, see, and smell
Subjective documentation - something you cannot observe such as what a resident tells you they heard, felt, saw, or smelled

Documentation Basics:

- **In documenting care you are recording and communicating information about the residents and the care that is given to them.**
- **The communication of this information among facility staff ensures teamwork, shared responsibility, and continuity of care.**
- **It ensures the facility complies with the rules of residential care or assisted living which are legal requirements to protect residents and the facility in which they live.**
- **Proper documentation reflects the quality of care given to residents.**

Why Document?

- There is an old saying: "if it's not documented in the resident's record it was not done." Documentation reflects the quality of care that you give to your residents.
- Your documentation reflects the story of the resident's health status over time. Failure to document is risky and should be avoided. If caregivers have questions they should ask the Administrator.
- Facilities develop a variety of formats upon which to document.

Regardless of the format used to document, it is a formal, legal document that details changes in a resident's behaviors and mental or physical health status.

- Caregivers provide care to many residents however documentation is an important part of resident care.

What this means to you

- Your documentation communicates care provided to each resident.
- Your documentation is used by other facility provider team members to make changes in the care residents' are to receive.

Rules of documentation:

- The facility is responsible for what is documented.
- You should not document for another person.
- Do not skip lines or leave blank spaces.
- Document as soon as possible after giving care.
- Your documentation needs to be legible to anyone who may read it. You may print if it makes it easier for others to read what was written in the notes.
- When documenting, include the date and the time the entry was written. The date should include the year. The time should indicate am or pm. Don't document in blocks of time such as 7:00 a.m. to 3:00 p.m. This makes it hard to determine when specific events occurred.
- It is important that you document any subjective information and objective observations; especially changes in behavior, mental status or physical health.
- It is acceptable to chart the resident's verbal responses in the record as long as quotation marks are used. Non-verbal responses should be described in as much detail as possible.
- You should record your full name and job title in the required section on documentation forms. The signature should be legible.

What this means to you

- Documentation needs to include objective and subjective information
- When documenting be careful not to document personal opinions such as "The resident is cranky today."
- Document subjective information by documenting what the resident said, i.e., The resident said, "go away and leave me alone, don't talk to me."

Documentation Do's:

- Make sure you are writing in the correct resident's record.
- Use ink.
- Write legibly.
- Document completely, concisely, and accurately (tell it like it is)
  - Write clear sentences that get to the point.
  - Use simple words.
- Document as soon as possible after giving care.
- Document a resident's refusal to allow a treatment or cares.
- Document often enough to tell the whole story.
- Make sure each page has the resident's name.
- Document what someone else said, heard, felt, or smelled, by using quotation marks.

Documentation Don'ts:

- Don't include what you supposed happened, what you think happened or what you concluded happened.
- Don't use words like "drunk, loony, nasty, or mean".
- Don't record staffing problems, staff conflicts, or casual conversations with your co-workers.
- Don't write in the margins.
- Don't use white out or "scribble-out" mistakes.

Areas where written documentation is required:

- Care notes.

- Incident/Accident reports.
- Medication Assistance.
- Behavior Management Program.

Care Notes:

- Document when the NSA is not followed such as when a resident refuses cares.
- Document the facility's response to the refusal of cares.
- Document that the resident or the resident's legal guardian has been informed of the consequences of the refusal of cares.
- Document the delegated tasks such as treatments, wound care, and daily assistance with medications.
- Document unusual events such as incidents, accidents, reportable incidents, and altercations.
- Document the facility's response to those unusual events.
- Document calls to the resident's physician or authorized provider, the reason for the call and the outcome of the call.
- Document when you notified the licensed professional nurse of the changes in a resident's health status.

What this means to you

- Documentation is an important part of communication between the facility's provider team.
- When documenting in the resident's record you should document what you saw, heard, felt, smelled, counted, and measured.
- When caregivers document a change in mental or physical health status they are communicating the resident's needs to other team members.

Incident/Accidents:

- The person who discovered the incident should be the one who fills out the incident report.
- The information needs to be clear and accurate.
- Write only what you see, hear, feel, count and measure.

- Write the correct date and time the incident was discovered.
- Write the date, time and person notified of the incident.
- Do not include what you supposed happened or what you think happened.

What this means to you

- Document:
  - Who was involved
  - What happened
  - When it happened
  - Where the incident happened

Medication documentation:

- Document daily assistance with medications.
- Document medications refused by the resident.
- Document medications not taken by the resident along with the reason.
- Document medications not taken by the resident along with the reason not taken.
- Document when a PRN (as needed) medication is taken by the resident along with the reason.

What this means to you

- When you assist with medications you must document:
  - Daily assistance with medications.
  - Refusal of medications
  - When residents are not assisted with medications
  - When residents do not take medication they were assisted with
  - When residents ask for a PRN (as needed) medication
  - When you realize a medication error was made

Behavior documentation:

- The person who witnessed the resident's behaviors should be the one who documents those behaviors.
- Document only what you see, hear, feel, count and measure.
- Don't include what you supposed happened or what you think happened.
- Write the date and time of the entry.

What this means to you

- Document:
  - Who was involved
  - What happened
  - When it happened
  - Where the behavior happened
  - Why this behavior is different from normal behavior

As said previously in this module, how you chart is as important as what you chart therefore, chart only what you see, hear, feel, measure and count…not what you suppose, assume, conclude or think.

Learning exercise:

Directions: Circle the best answer to each question.

1. If you provide care and do not document it, then the care:

   A. was done

   B. was not done

   C. was done by yourself and a co-worker

   D. none of the above

2. All of the following information should be included when you document in a resident's record except:

   A. the date
   B. the time
   C. your name
   D. a problem you have with a co-worker

3. All of the following statements are true except:

A. do not use white out if you make a mistake
B. documenting care ahead of time is okay
C. do not document your opinions
D. chart as soon as possible after giving care

Scenario: Brian is pacing in his room. He tells you he has sharp pains in his stomach. Brian doubles over and grabs his stomach. Brian screams, "My appendix burst!" He passes out.

4. Identify the subjective information in the above scenario. Circle the best answer.

A. Brian is pacing and passes out
B. Brian says he has sharp pains and that his appendix has burst
C. Brian is pacing and screams
D. Brian says he has sharp pain and passes out

5. Identify the objective information in the above scenario. Circle the best answer.

A. Brian is pacing and passes out
B. Brian says he has sharp pains and that his appendix has burst
C. Brian is pacing and screams
D. Brian says he has sharp pain and passes out

TRUE AND FALSE

Directions: Circle **T** for true or **F** for false in the following questions. Completely erase and mistakes.

T F 7. A change in a resident's physical condition should be documented

T F 8. Documentation should be clear and legible

T F 9. To save time it is okay to document care before it is given

T F 10. You should write your name so anyone can easily read it

T F 11. When a resident refuses care you don't have to document anything

T F 12. When you make a mistake in documentation it is okay to erase the note and start over.

ANSWERS:

1. B
2. D
3. B
4. B
5. B
6. A
7. T
8. T
9. F
10. T
11. F
12. F